Building a Collaborative Team Approach to Healthcare

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Problem Statement

Multidisciplinary treatment teams are commonly used in healthcare as a method to help promote recovery. The National Council for Mental Wellbeing (2021) reports that "implementing team-based care for psychiatric clinic services can improve treatment quality, patient experience, profitability and reduce burnout and improve retention of psychiatric providers." Professionals with varying skillsets are able to provide fresh perspectives on patient care and support for each other in the process. When treatment providers operate in silos, and do not have input on a patient's care as part of a team, the work in a Community Mental Health Center becomes extremely frustrating (Walker, 2015). Patients feel this frustration too. Having access to a multi-disciplinary team is the gold standard for those with serious mental illness (von Peter, 2018; Liberman, 2001). Having this access promotes a system of responsive care, particularly for those with acute need (Schuttner, 2018). Additionally, Frank and Gunderson (1990) found that patients forming a good alliance with their treatment providers within the first 6 months exhibited more medication adherence and had better outcomes.

We have seen this multidisciplinary team approach firsthand at Spartanburg Area Mental Health Center (SAMHC), an outpatient mental health center through the South Carolina Department of Mental Health. People with First Episode Psychosis often have a unique set of challenges in their care. A specialized treatment program, entitled NAVIGATE (Mueser, Penn, et al., 2015) was developed and implemented at SAMHC in 2021. The staffing for the NAVIGATE program is multidisciplinary, with all members working together to provide wraparound treatment for those diagnosed with first episode psychosis. Weekly treatment team meetings, to include the patient as a partner in their recovery, are crucial to the success of this program.

How would the reorganization of all staff into treatment team pods impact patient care for those seeking treatment for serious mental illness? SAMHC has a staff of 160 people, serving 7500 patients each year. Commonly, patients present seeking treatment for depression, anxiety, schizophrenia, and trauma related conditions. However, as the mission of the SCDMH is to support the recovery of those with mental illness, treatment services are not limited to just a few diagnoses and treatment is provided for a myriad of diagnoses as found in the Diagnostic and Statistical Manual (DSM). We ask our staff to have skills in treating a wide variety of psychiatric conditions, which may seem a herculean task at times.

There was not a strong, strategic, calculated process for placing patients into care at Spartanburg Mental Health. When patients entered into care, a case manager and a physician were assigned based on a minimal number of parameters, in a disorganized manner. Some patients were assigned to providers based upon specific criteria (the school they attended, the Community Care Residential Facility in which they resided) but most were assigned based upon first available appointment slots. Attempts were made to align incoming patients to staff with certain clinical skills or interests, but logistically this was not always possible for a myriad of reasons (staff turnover, high number of cases, etc.) We needed a process that would provide access to care for patients in a way that met the treatment needs and presenting problem of the patients, and that built communication and resiliency among the care providers. A process was needed that also was able to ensure that patients were seen quickly once entered into care, and where staff were able to meet the target patient care hour benchmark as set forth by the Department of Mental Health. In Executive Management Team meetings consisting of Medical Director Dr. Ebony Gaffney, Chief of Staff Jeffrey Greene, Chief of Finance/IT Manager Tamer Elshennawy, and Clinic Director Kristin James, these questions were asked and a plan

developed. By organizationally grouping and physically relocating staff into smaller treatment team units, I would hypothesize that patient care would be improved. My questions are will this increase access to services, increase patient engagement in their care, and increase team cohesion and awareness of internal resources to aid in patient recovery?

Data Collection

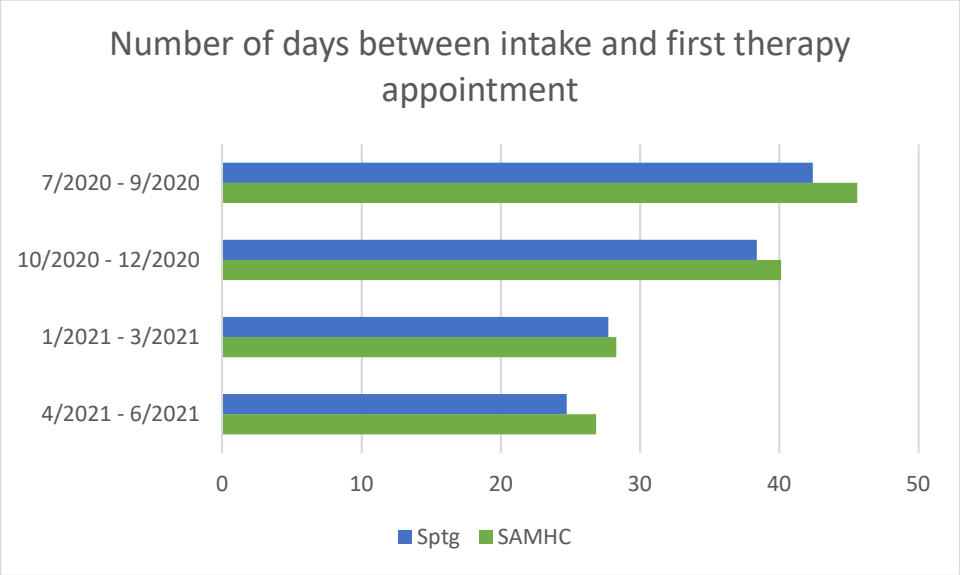
So, what does the data show? The primary source of data was our Business Intelligence Platform ("Crystal") that pulls patient care data directly from our Electronic Medical Record. Data was pulled on a monthly basis (or more frequently as needed) to assess effectiveness of the service model as it related to services that our patients received. This data was reviewed on a monthly basis, and management made educated guesses as to how to improve processes so as to improve timeframes for care. It is through this spirit that the data below was analyzed as the basis for attempting to solve a problem: how do we make sure we provide access to care or our patients and that patients are seen for services in an expedient manner while not overtaxing already burdened staff. The following reports were analyzed from this system:

- Number of days from entry into care (intake) to first appointment with a clinician
- The rate at which patients keep their appointments, or do not show up for their appointments without calling to cancel or reschedule (appointment status)
- Productivity of staff, or Patient Care Hours (number of hours spent in direct patient care)
- Surveys to assess staff and patient satisfaction

Data Analysis

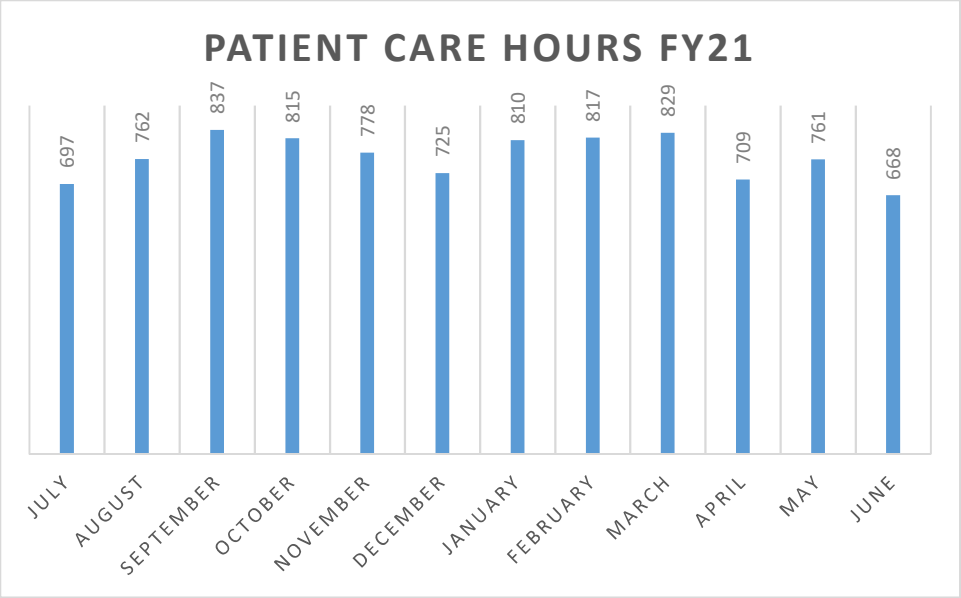
Number of days between intake and first therapy appointment

The Department of Mental Health holds the standard that new patients are seen in less than 30 days from time of intake to first appointment. As can be noted from the graph below, the number of days between first contact with our clinic to the time of the first therapeutic appointment started to decrease over the course of fiscal year 2021. In July 2020, it took a patient seeking services almost 45 days to see a clinician, whereas in June 2021 that number was down to 26 days. Not providing services in a more expedient manner is a problem area.



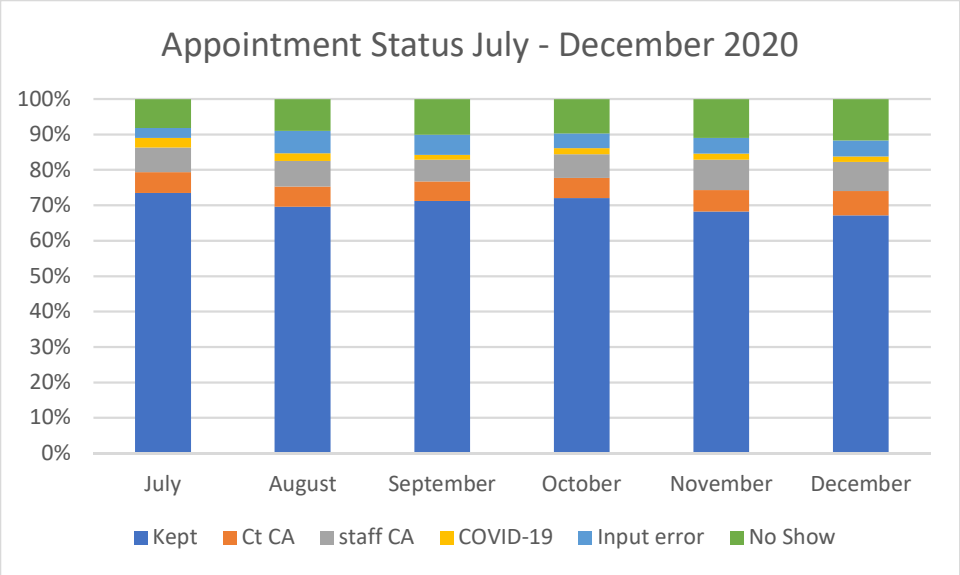
Patient Care Hours (productivity)

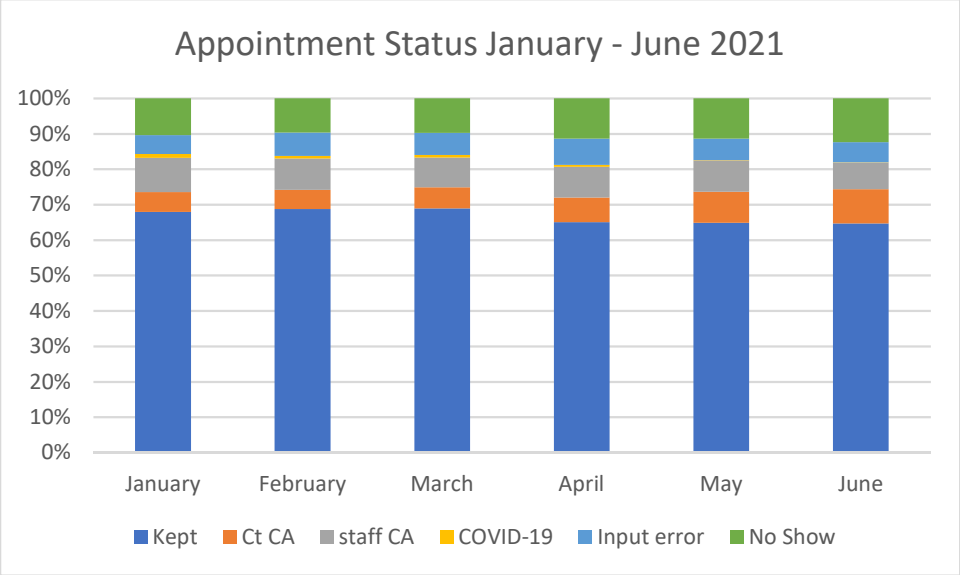
The number of patient care hours, listed below, shows that Spartanburg Area Mental Health Center is not meeting the state standard target of 803 hours monthly. During the past 12 months, SAMHC has met this standard only five times and averaged 767.33 hours per month. Data shows that 95.7% of the standard is met on average, even considering seasonal variability. Not consistently meeting this target is also a problem area for SAMHC.



Appointment status

Although appointment status is not core to the thesis because of the small standard deviation (1.28 from the mean of 10.41), this became an ancillary data point to investigate. Although we focused on the other two data points as previously discussed, we decided to look at no show rates and were curious to see if there was any effect. As can be seen below, the number of appointments that were listed as a No Show (patient did not keep a scheduled appointment, and did not call or cancel beforehand) were an average of 9.95% of all scheduled appointments for the 1st half of FY21 and 10.87% for the 2nd half of FY21. The most common barrier preventing patients from keeping their scheduled appointments is transportation: lack of, or unreliable sources. SAMHC has attempted to alleviate that barrier by maintaining communication with area transportation resources, paying for transportation, using staff to transport, or offering gas cards to our patients to pay for the gas to come to appointments.





Two problem areas were identified: 1) We were not seeing patients after intake as soon as is medically necessary; and 2) Our staff were not meeting state standard patient care hours benchmarks. What if we placed patients into treatment team pods, in an intentional manner. What if we set the standard that patients would be able to access a team of providers to assist in their recovery? Would patients feel less frustrated if we were able to engage in therapy more

quickly after their seeking services? Would staff members feel more supported knowing they could rely on a team to help in providing treatment, rather than trying to manage on their own? If we redesign and go to a team approach, will we decrease our no-show percentage from 10% to 5%, thereby increasing overall patient care hours?

Implementation Plan

The treatment team concept is not a new process in healthcare, but it is one that is a dramatic shift in the culture of SAMHC. The aim of this project was to reorganize a three-floor clinic into smaller treatment team pods, and co-locating staff across all disciplines so that they were on units together. This would mean that a patient would be assigned to a particular team of people upon opening the case (counselor, Peer Support specialist, APRN, Nurse, Psychiatrist, Admin Support, Care Coordinator). The theory was that by assigning patients to treatment team units, staff would be more productive, be able to see patients quicker, and have fewer appointments that are not kept by the patient.

Actions steps needed to complete the goal (and who performs them)

The first step was to plan the restructure and the logistics of moving around a clinic of staff, some of which had been in the same offices for years. Executive Management team met on a weekly, sometimes twice a week, basis to identify a plan and lay out the map regarding office moves. Staff were placed on treatment team pods in a deliberate fashion, so as to offer a variety of experience, treatment interests, and positions within the agency. Each team was assigned at least one physician, nurse, peer support specialist, care coordinator, and administrative assistant.

Several clinicians are placed on each team. Office space was then sorted in order to co-locate most members of each team.

Training staff on what the treatment team model was, and what the expectations would be, was the second step. A plan was laid out to train treatment team pods systemically and deliberately, so that not everyone was trained at the same time. Training was created by the Executive Management team to last for 4 weeks: introduction, logistics, mock treatment team, and live treatment team (see Appendix 1 for training schedule). Each session was led by the Executive Team and all members attended each training session. Training sessions were held once a week for four weeks, from 8:15 -9:00 am, the same time that all treatment teams are held. Once treatment team pods received the introductory training, staff were given time frames to move into their new offices. Upon closure of the four-week training period, treatment team pods were expected to go live with their own treatment teams on a weekly basis.

Timeframes and cost

	April	May	June	July	August	September
Training	LAT	3 Adult	2 CAF	2 CAF		
	Intake		ICT/TLC	Navigate		
Action		LAT	3 Adult	2 CAF	2 CAF	
		Intake		ICT/TLC	Navigate	
Evaluation			LAT	3 Adult	2 CAF	2 CAF
			Intake		ICT/TLC	Navigate

As can be seen above, the training period began in April, with the Long Acting Treatment and Intake Treatment Teams. These two teams moved into the Action phase in May, which consisted of moving office spaces, building rapport within the teams, starting the process of moving appropriate patients to those specific team providers, and holding weekly treatment team meetings. In June, these two teams entered the evaluation phase, completing surveys on their

experiences, undergoing observation from Executive Management to assess model fidelity, and problem solving any unresolved logistical issues. At the end of the evaluation period, staff surveys were distributed to assess thoughts on implementation and effectiveness (see Appendix 3 for data).

Each team as listed above followed the same path for Training, Action, and Evaluation. At the beginning of this process, 7 treatment team pods were identified – this number would increase upon conclusion of evaluation period for all teams.

The cost for this project was fairly minimal regarding expenditures. Pamphlets were developed to hand to each patient seeking services so as to explain the treatment team model. Labor cost was the biggest expense, with the large amount of time it did take staff to physically move their offices, and time spent in learning and practicing the new process.

Potential obstacles and methods to overcome them

Resistance to change was the primary obstacle faced during this project. As stated above, this model is a dramatic culture shift for Spartanburg Area Mental Health. This meant that staff would have to rearrange their schedules, come to work earlier one day a week, and report to the clinic rather than out-based locations for those staff stationed in schools and long-term care homes. To overcome this resistance, the two weeks of training in the treatment team model were crucial in identifying specific reasons WHY this change was a positive change for patients as well as staff. Training also focused heavily on the support that would be afforded staff with regards to taking care of seriously mentally ill patients. Prior to this shift, staff were frequently left alone to provide treatment in virtual isolation, to staff cases with a supervisor or a provider

when they could catch them. Educating staff as to the benefits, versus the costs of continuing to operate in the same old pattern, seemed to help alleviate some concerns.

In the early stages of planning, mid-level management staff did not feel their ideas or suggestions were taken into consideration. After the first round of training began, and supervisors were as included as they felt they wanted to be, a diligent effort was made prior to the second round of training to give supervisors the time to voice their concerns. Even if changes to the model were not made, this time allowed them to at least be heard.

Another identified obstacle focused around the initial number of treatment team pods. Other pods were added to lessen the number of staff on each team, and teams were added for the Cherokee and Union Clinics, as well as Deaf Services, bringing the total number of treatment team pods to thirteen. This doubled the number of teams compared to the initial planning stage. An outline of the treatment team listing for Spartanburg teams can be found in Appendix 4.

The pandemic has certainly impacted this model. Treatment teams depend on consistent staff in order to provide care, and each position is critical for model fidelity. With staff turnover at alarming rates, it has been difficult to replace positions on each pod. One benefit that we are seeing is that when staff are hired, management focuses more on which treatment team would be the best fit and works to hire staff with this in mind. However, on going assessment to model fidelity, and frequent participation in treatment teams to provide ongoing training has to occur regularly.

Potential resources

Community partners and other stakeholders with a shared interest in designated patients can be invited to attend treatment team to staff a particular patient. Using other partners

involved in care to work within the treatment team model helps to build a village of care for the patients served. As the Department of Mental Health falls under the medical model for patient care, providing dedicated time by medical providers to talk through challenging cases puts this focus into practice.

Communication with key stakeholders

Community partners and other stakeholders are educated regarding this new model. Although we have not progressed far enough to invite outside providers to the treatment teams at this time, this remains a long-term goal.

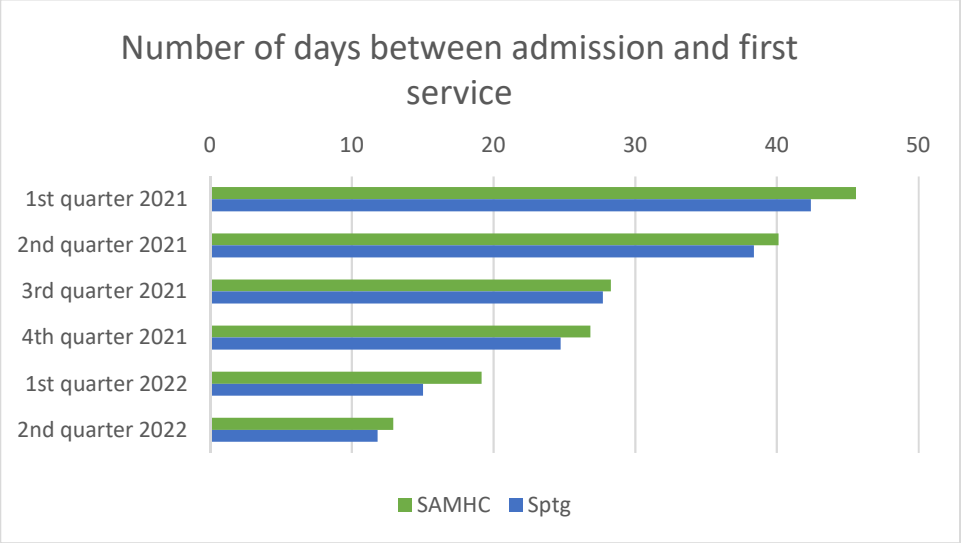
Integration into standard operation procedure

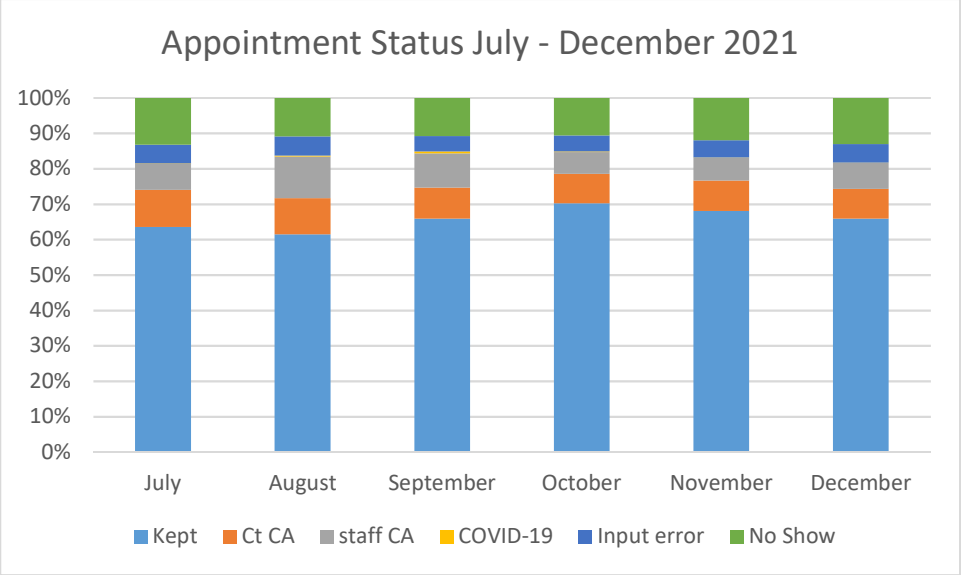
Have you staffed this in team? This question is the typical answer when staff present treatment questions to individual supervisors or management. Diverting staff to the team to staff challenging issues has become an automatic response. By stressing the model, supervisors and management help to integrate treatment teams into our standard operations, and reinforce that this model is here to stay.

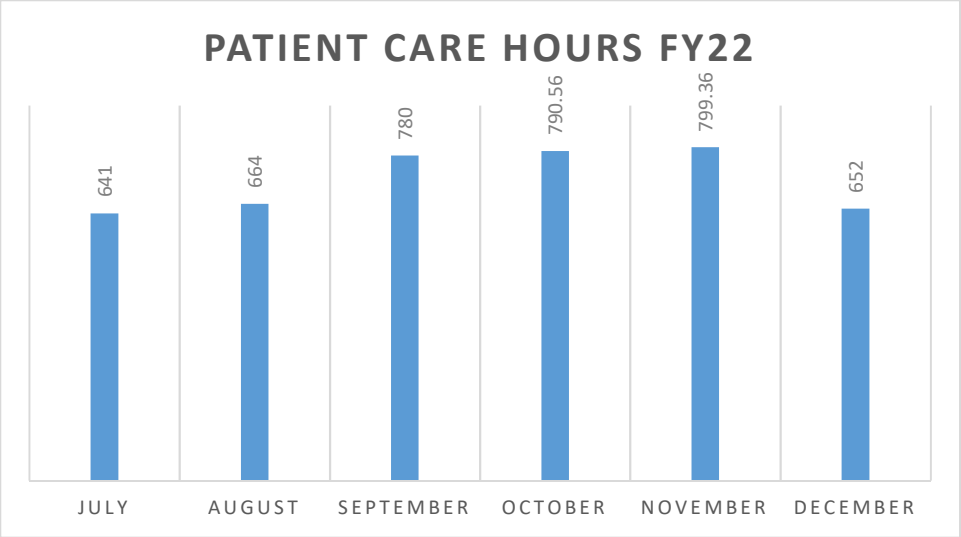
Evaluation Method

Data will continue to be pulled on a monthly, or more frequent basis, regarding time from intake to first therapy appointment, rate of appointments not kept, and patient care hours provided. As can be seen from the charts below, we have already seen some success with the decrease in number of days from intake to first therapy appointment throughout this process. It

does not appear that such progress has been made at this point with appointment status nor patient care hours.







Staff surveys have been provided throughout the training process, as well as post implementation. Data from surveys is used to help identify gaps in training, or other issues needing to be addressed (see Appendix 3). Overall, staff seem to find benefit in the treatment team model that has been implemented. Approximately 60% of staff that responded to the survey are finding treatment team useful in linking patients to resources and finding it at least moderately helpful in performing the duties of their jobs. Treatment team on average is lasting the expected duration and most positions are represented on a regular basis. Patient satisfaction surveys are in development.

Over the next 6 months to one year, we are planning to review the data on first therapy appointment, rate of appointments not kept, and patient care hours provided to see if implementation has been successful. Continuing goals include having all patients seen within seven days for the first therapy appointment after intake, decrease the rate of appointments not kepy by 5%, and increase patient care hour provided by 10%.

Summary and Recommendations

Treatment teams are an evidenced based approach to providing patient care. This model is an approach to take this a step beyond and to implement treatment team pods, by building teams of care within a mental health facility. Teams of care help provide an array of services for patients, and also provide desperately needed support and guidance for staff treating those with serious mental illness. Guiding staff through this culture staff was difficult, and not a perfect process. We encountered bumps along the way, and are still finding deviations from the intended model. And we have yet to fully separate 7000 patients onto their appropriate teams. But, with supervisors and management reinforcing this model, staff educating patients about this model, and building knowledge within our communities as to how this benefits the whole village of care providers, we are poised for success. But our work does not stop here and we must take treatment teams one step further: to include the patient as an active member of their treatment team. Shared decision making has shown a positive benefit in treatment for those seeking care. By laying the foundation, we are creating a process to allow patients to take charge of their recovery and engage their treatment team providers to help them on this road. What an empowering idea.

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Appendix 1

Treatment Team Training Agenda

Day 1: Introduction/Purpose

1. Goals of day 1:
    a. Identify your team
    b. Learn by listening
2. Review Introductory PowerPoint
    a. Discussion
3. Team Builder
    a. Role Expectation
    b. Discussion
4. FAQ/Feedback Form

Day 2: Preparation and Planning

1. Rotation of Clinicians
2. Case Setup/Collection
    a. Priority of Cases (Team Lead)
    b. Materials needed to present/prepare
    c. Transfers from other teams
3. Documentation
    a. Admin support
        i. Weekly attendance (form)
        ii. Cases presented with recommendations (form)
        iii. Place assigned team in Alert on every chart
4. Billing

Day 3: Practice

Mock treatment team

Day 4: Complete Integration

Facilitated treatment team

Appendix 2

Adult Services 1 Treatment Team Case Plan/Summary

Date: Click or tap to enter a date.

Patient Name: Click or tap here to enter text.

Patient CID: Click or tap here to enter text.

Those in Attendance:

☐Ebony Gaffney, MD
☐Katie Rush, APRN
☐Elizabeth Cunningham, APRN
☐Dee Richardson, RN
☐Nikki Compton
☐Cambia Williams
☐Alisha Tyler
☐Riley Lanier
☐Andre Dawkins
☐Debbie Green
☐Jeanna Harrison

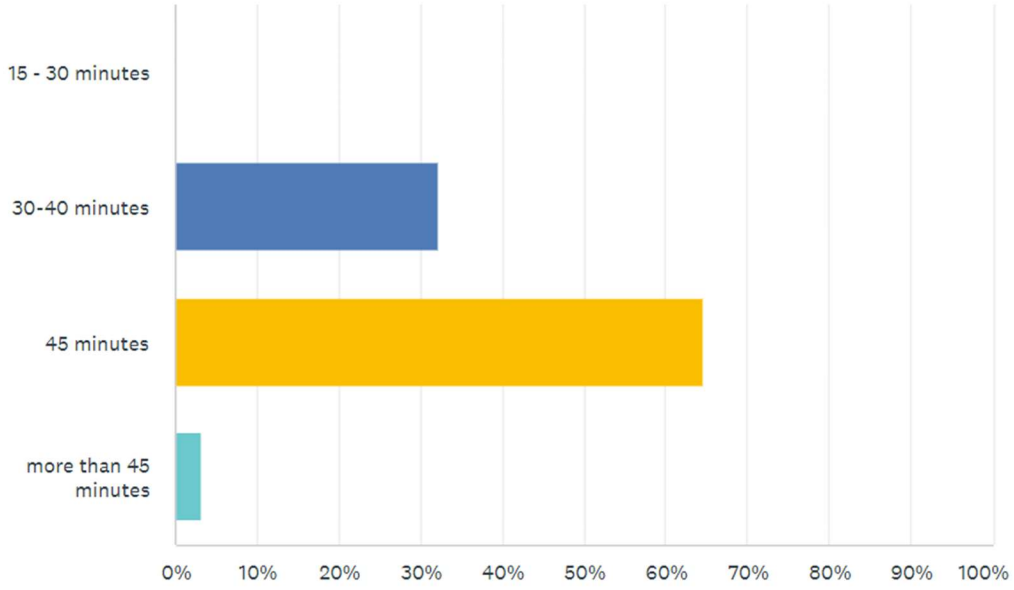
Staffing Category: Select one

Provider	Presenting Staff	SPD Time	RECOMMENDATIONS (with responsible party)
Choose an item.	Choose an item.	Click or tap here to enter text.	Concern: Click or tap here to enter text. Recommendations: Click or tap here to enter text.

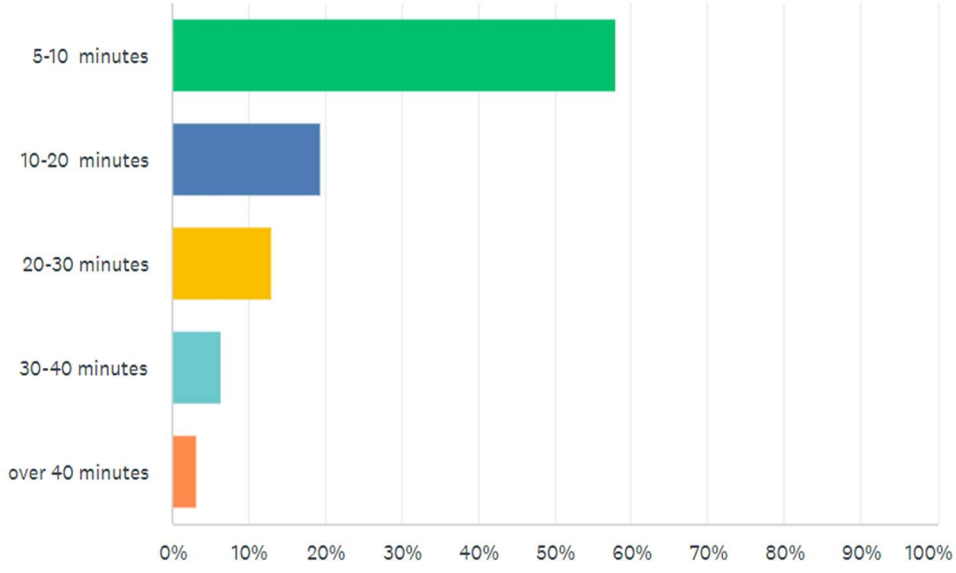
Appendix 3

STAFF SURVEY RESULTS

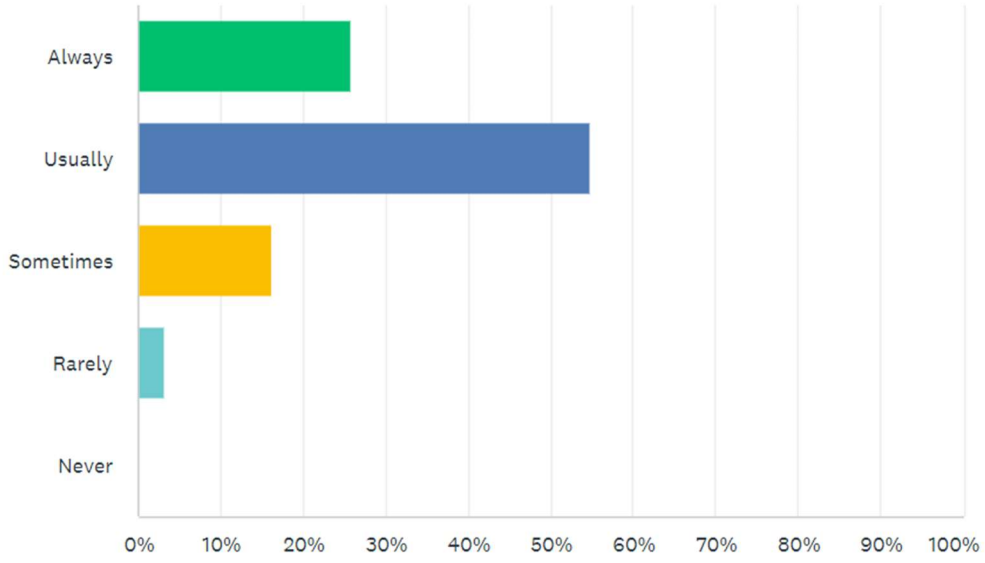
How much time do you spend in treatment team?



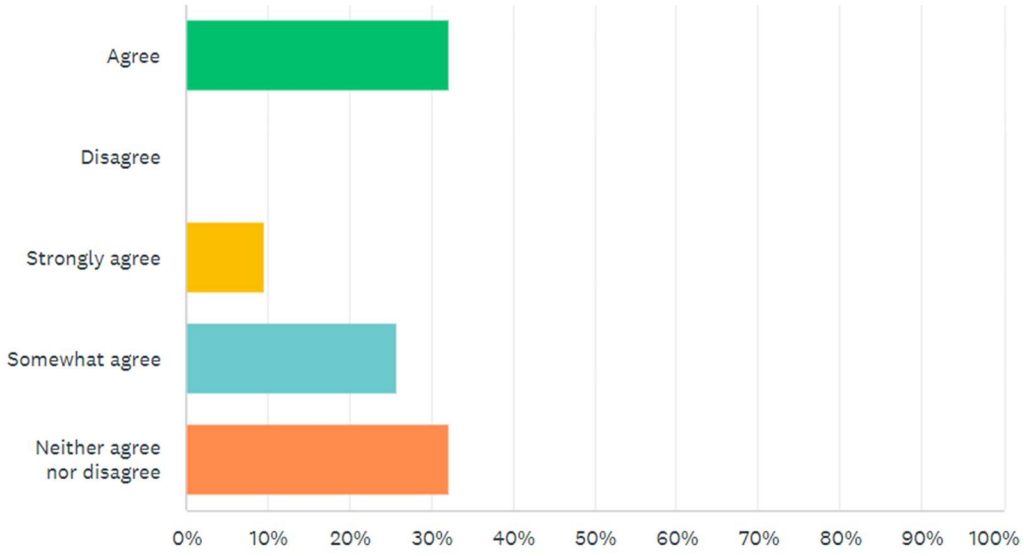
How much time does it take to prepare for treatment team?



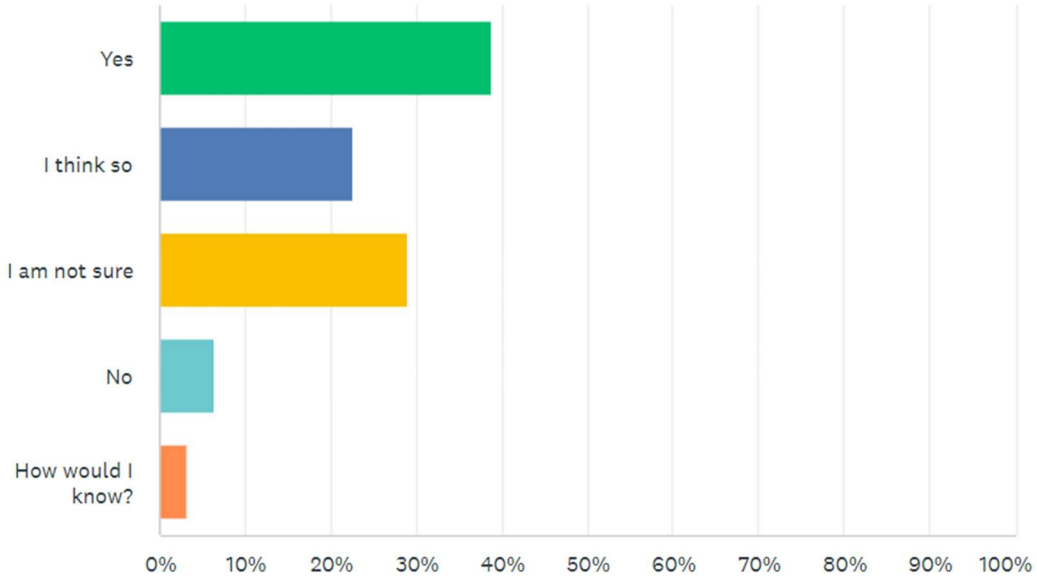
Does your team have representation from each role/position on a weekly basis?



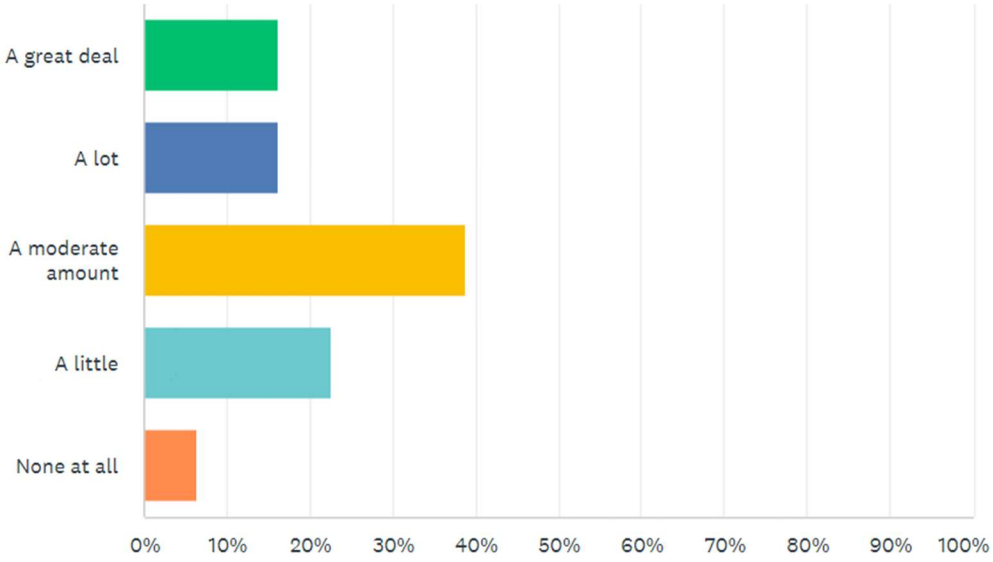
Is it easier for you to link patients to resources with SAMHC as a result of treatment team staffings?



Designated staff are following up with recommendations of the treatment team, and are following back up with the team on outcome



Does the treatment team model that we have implemented meet your expectations and enhance your ability to be successful in your position with SAMHC?



Appendix 4

Team	Location	Provider	APRN	Nurse	Clinician	PSS	CC	Admin	Tx Team time
Intake	**1st floor**	Dr. Warren (181)	Monroe	Monroe	*Carrie Pettit	Lavinia Holder	Tomeca Ware 325	Veronica Morris	Wed 8:15-9:00
	North	Dr. Afrin (doxy)			Jerome Wicker (168)			b/u Nicole Jaworsky	Kitchen
					Julia Allen				
					Bethany Baynard				
					Andrew Jobe			3rd - Tasha Miller	
					Christopher Fenner				
					Heather Crutchfield				
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
LAT	**1st floor**	Dr. Gaffney	Dr. Seegars (183)	Nereyda	*Philip Porter (226)		Tomeca Ware 325	Nicole Jaworksy	Tues 8:15-9:00
	North							b/u Tasha Miller	Kitchen
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
CAF	**1st floor**	Dr Barwick (131)	Rush (215)	Dionte	*Lori Thornton	TBD		Sydney Shelley	Tues 8:15-9:00
SMH	South	Dr. Sood (tele)			Cristin Wood				
D1, 2, 7					Erin Cato				
					Wendy Stacey				
					Amanda Ledford				
					Robert Bain				
					Sarah Dame				
					LaMonica Woodruff				
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
CAF	**1st floor**	Dr. Barwick (131)	Rush (215)	Dionte	Kristin James			Sydney Shelley	Wed 8:15-9:00
in house	South	Dr. Menendez			Veronica Perez				alternating
		Dr. Brown (113)	Dr. Seegars (183)		Jessica Smith				
					Tonisha Lee				
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
CAF	**1st floor**	Dr. Brown (113)	Dr. Seegars (183)	Dionte	*Lori Thornton			Sydney Shelley	Thurs 8:15-9:00
SMH	South				Simone Anderson				
D4,5,6					Chelsey Dawkins				
					Connie Permar				
					Lori Micke				
					Jamie Baston				
					Amber Schrenkel				
					Latoya Downs				
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
Adult	**2nd floor**	Dr. Ski (210)	Rush (215)	Dionte	Nikki Compton (209)	Lavinia Holder (205)		Courtney Owens	Tues 8:15-9:00
1	South				Alisha Tyler				
					Cambia Williams (205)				
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
Adult	**2nd floor**	Dr. Bhatia (270)	Monroe	Nereyda Velencia	Katherine Garland (250)	Lavinia Holder (205)		Paula Gilliam	Thurs 8:15-9:00
2	North				Tyrone Whitener (247)				
					Alexis Dawkins				
					Monique Bullock				
					Nikita Gonzalez				
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
Adult	**2nd floor**	Dr. Edwards (322)	Mathewson	Nereyda Velencia	Nikki Compton (209)	Lavinia Holder (205)		Carole Zabele-Thomas	Mon 8:15-9:00
3	North				Julie Turner (261)				
					Christy Barker (264)				
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
Navigate	**2nd floor**	Dr. Gaffney (270)	TBD	TBD	Philip Porter		Katrina Hereford	Jeanna Harrison	Mon 2-4
	South				Brad Peterson				206
					Danielle Morton				
Team	**Location**	**Provider**	**APRN**	**Nurse**	**Clinician**	**PSS**	**CC**	**Admin**	**Tx Team time**
ICT/TLC	3rd floor	Dr. Edwards (322)	Mathewson	Dionte	Bailey Bridges	Chris Knight	Tomeca Ware (325)	Carole Zabele-Thomas	Wed 8:15-9:00
	North				Courtney Cork				AS group room
					Lisa Peake				
					Marianne Thomas				
					Margaret McAdams				
					James Brewton				
					Coral Bower				
					Shaterrica Jones				
					Bruce Patrick				
					Tina Reitmeier				
					Kim Rice				
					Amie Shaver				